

New Jersey Small Employer Health Benefits Plans General Information

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For a more detailed explanation of the Small Employer Health Benefits Program, please consult the law codified at N.J.S.A. 17B:27A-17 et seq.) and Program regulations (N.J.A.C. 11:21-1.1 et seq.)

This document outlines the basic rules that apply to health coverage for small employers. Do not rely on it for the details of the law or your specific rights and obligations under a health benefits plan contract. Read your contract carefully and consult a carrier, broker, agent or attorney if there is anything you do not understand.

The New Jersey Small Employer Health Benefits Program has a very useful Web site that you can visit at any time. The address is: www.nj.gov/dobi/reform.htm. If you are an individual shopping for health benefits for yourself and your family, you should consult a similar buyer's guide for individual insurance which may be obtained free of charge by dialing: 1-800-838-0935. The New Jersey Department of Health and Senior Services publishes a performance report of HMOs which may be obtained free of charge by dialing: 1-888-393-1062.

Introduction And Summary

In 1992, the New Jersey Legislature enacted two laws that give individuals and New Jersey small employers guaranteed access to health coverage. If you are a small employer currently offering group health benefits to your employees, or if you would like to do so, you need up-to-date information on your rights and responsibilities under New Jersey's health coverage reforms. This document explains the basic provisions of the law so that you may understand changes that will affect your existing coverage, and so that you may shop intelligently for new coverage.

If you employ at least two but not more than 50 employees, in most instances you will be considered a "small employer" eligible for guaranteed access to small group health benefits coverage. You are also required to have a minimum number of full-time employees participating in the plan (75 percent), and to contribute a minimum percentage to the cost of the group plan (10 percent). Section I sets forth eligibility, participation and contribution requirements in greater detail.

Section II outlines some of the key features of all small group health benefits plans. For example, all small employer plans must be issued on a guaranteed issue/guaranteed renewal basis, pre-existing condition limitations may be imposed only under certain limited circumstances and may not be imposed for periods longer than six months, and plans may be rated only on the basis of age, gender, and geographic location of the group.

You can receive additional assistance from insurance companies, health maintenance organizations, and service corporations (referred to collectively as "carriers") which offer small employer health benefits coverage. A list of carriers offering small group health benefits coverage, with their toll free numbers, appears as an insert to this Guide. You can also receive assistance from agents selling small employer coverage; they can be found by referring to the YELLOW pages or similar telephone directory under "Insurance" or "Health Maintenance Organizations," but be aware that agents do not offer all carriers' plans.

Section I:

If your company meets the definition of a "small employer" and satisfies the participation and contribution requirements described below, then you are guaranteed access to small group health benefits coverage.

Am I A Small Employer?

Your business is a "small employer" if it meets the following requirements:

- It employed an average of at least two but no more than 50 eligible employees on business days during the proceeding calendar year;
- It employs at least two employees on the first day of the plan year; and
- A majority of its employees work at a location in New Jersey.

An "eligible employee" is defined as someone working 25 or more hours per week on a regular basis, but excludes union employees who have collectively bargained for their health plan. While you may have, for other reasons, a different measure of what constitutes a full-time employee, for purposes of health coverage, you must use the law's definition of an "eligible employee."

If you have affiliated companies, they are treated as one company. Companies are considered affiliates if they are treated as a single employer under the Internal Revenue Code. All eligible employees of all affiliated companies, including employees of out-of-state affiliates, are considered in determining eligibility.

If the number of eligible employees of affiliated companies when combined exceeds 50 eligible employees, the affiliated companies are not eligible for small group coverage. Your agent, broker or carrier can assist you in determining whether your companies are considered "affiliated companies."

What Is A Participation Requirement?

A carrier will require that up to 75 percent of your eligible employees participate in a health benefits plan you offer. However, an employee who is covered by a spouse's health benefits plan (except an individual plan), Medicare or another group health plan is counted as if they were participating under your plan, even if the employee declines coverage under your plan. In addition, if you offer your employees more than one type of health benefits plan, employees covered under other plan that you sponsor count toward the 75 percent participation requirement.

What Is A Contribution Requirement?

A carrier will require you to pay up to 10 percent of the total cost of a health benefits plan. For example, if the total cost of a plan for all employees and dependents was \$10,000 per year, a carrier could require you, the employer, to contribute up to \$1,000 per year. Of course, you may always pay a greater percentage, up to 100 percent of the entire premium.

The Following Example Will Help Illustrate These Eligibility Rules:

Calculation Of Size Of Employer

Company ABC	25 employees
Company XYZ	34 employees
(companies are affiliated)	
Total	59 employees
Subtract	
Employees working less than 25 hours per week	15 employees
Employees covered by union benefits plan	10 employees
Total Eligible Employees	34 employees

Calculation Of Participation Requirement Of 75 Percent Requirement

75% of 34 "eligible employees"	26 employees
Credit Towards Requirement	
Employees covered by spouse's plan	5 employees
Employees participating in other coverage you offer	9 employees
Minimum number of employees who must enroll to obtain coverage (26-(5+9))	12 employees

Section II: How Your Coverage Is Affected

All small employer health benefits plans must meet certain minimum requirements referred to in this Guide as "features of reform." These features of reform include the following:

Guaranteed Issuance

No eligible small employer group (as described in Section I) or member of the group may be denied coverage, regardless of health, prior claims experience, age, gender, occupation, nature of business, location of the business in New Jersey, or any other factor.

Guaranteed Renewal

No eligible small employer group (as described in Section I) may be denied renewal of coverage, except for nonpayment of premium, fraud, or failure to meet a carrier's participation or contribution requirements.

Limits On Pre-Existing Condition Exclusions

A "pre-existing condition" is a medical condition which manifests itself within six months of a person's enrollment date and which was diagnosed or treated during that six-month period. Carriers may not consider a pregnancy to be a pre-existing condition. If your group consists of two to five eligible employees, a carrier may refuse to cover pre-existing conditions for persons covered under your plan for the first six months your coverage is in effect.

If your group consists of six to 50 eligible employees, a carrier may not impose a pre-existing condition coverage exclusion on any member of your group, with the exception of a person who is considered a late enrollee, who may be required to satisfy a pre-existing condition exclusion for up to six months. A "late enrollee" essentially is someone who requests enrollment in your health benefits plan following the initial 30-day enrollment period. A late enrollee does not include a person who was covered under another employer's plan at the time he or she first becomes eligible under your plan, who then lost coverage under that other employer's plan, and requests coverage under your plan.

If a pre-existing condition limitation period is applied to an eligible employee or dependent, that person is covered under the plan for those first six months for all conditions, except for the pre-existing condition. Generally, if a covered person were subject to a pre-existing condition exclusion under the circumstances described above, he or she would receive credit towards the pre-existing condition waiting period if he or she had prior coverage. Credit for prior coverage provides for portability, enabling a small employer to switch carriers without having to worry about new pre-existing condition exclusions. Creditable coverage includes individual or group insurance, self-funded health coverage, and any federally funded health benefits program (e.g. Medicare, Medicaid), that had not lapsed more than 90 days prior to the effective date of the new coverage.

Rating Restrictions

Carriers may consider only the age, gender, and family status of eligible employees, and the location of the employer in New Jersey in determining the premium for the group. Carriers may not consider any other factor, including health status or prior claims history of eligible employees or the type of business. Carriers are required to limit the range of premiums from the highest risk group and the lowest risk group to a two-to-one ratio.

Continuation Of Coverage (as applicable to plans issued or renewed prior to March 7, 2005)

Small employers with between two and 19 employees, and other small employers not eligible for continuation under the federal "COBRA" law, must offer employees the option to continue their group health coverage, at the expense of the employee, when an employee is terminated for reasons other than cause, when he or she goes to a part-time status, or if an employee ends employment. An employee on continuation would pay his or her premium to you, which you would remit as part of your regular premium payment. Employers have a legal obligation to notify their employees of the right to continue coverage at the time of termination or at the time the employee assumes part-time status. An employee has the right to continue coverage for up to 12 months.

The policy or contract issued to you and the certificate or evidence of coverage issued to the covered employees outlines the procedures that the employer and employee must follow for continuation of coverage.

Small employers with 20 or more employees generally must offer continuation of coverage under a federal law, commonly referred to as "COBRA," which contains provisions that differ from those described above.

Employer Contribution

As described in Section I, carriers will require you to pay up to 10 percent of the cost of a group health benefits plan.

Minimum Participation

As described in Section I, carriers will require that up to 75 percent of your eligible employees participate in the health benefits plan or plans you offer. Employees covered by a spouse's health benefits plan (except an individual plan) may decline coverage under your plan and still be counted as participating.

Section III: Commonly Asked Questions From Employers

Does The Law Require That I Provide Health Benefits For My Employees?

No. However, if you provide group coverage, you must comply with the requirements of the law.

If I Offer Coverage, Must I Offer It To All Employees?

No. However, if you do not offer coverage to all employees, any distinctions in deciding which employees will be offered coverage must be based on classes of employees, and the classes of employees must be based on conditions pertaining to employment (e.g., job title, length of service, salary, etc.). Other kinds of distinctions may not be legal.

In addition, you still must meet the 75 percent participation requirements based on the total number of eligible employees (i.e., employees working more than 25 hours per week). For example, in a group of ten employees, you would need eight or more employees covered either under your health benefits plan or plans or their spouses' plans (so long as their spouses' plans are not individual plans).

May A Self-Employed Husband And Wife Obtain Group Coverage Under The Small Employer Health Benefits Program?

Only if both are full-time eligible employees of the business. A carrier may ask for tax records for you and your spouse as proof that you are both bona fide employees. If only one spouse is working full-time and there are no other eligible employees, the couple may obtain only individual health coverage.

May A Small Employer Provide Coverage To Independent Contractors?

A small employer may elect either to cover all independent contractors or not to cover independent contractors. A person is an independent contractor if he/she: (1) is performing a service for the employer pursuant to a written contract for monetary or other legal consideration; (2) is working exclusively for the employer; (3) works 25 or more hours per week for the employer; (4) works on other than a temporary or substitute basis; and (5) the independent contractor relationship has been established to serve a substantial business need of the employer and is not intended primarily to obtain insurance coverage.

If I Offer My Employees A Health Benefits Plan, May I Impose A Waiting Period Before They Can Enroll?

You have the option of requiring a service waiting period of up to six months.

What If My Definition Of A "Part-Time Employee" Is More Or Less Than 25 Hours?

The law requires that you use the 25-hour standard for determining eligibility for health benefits plans. You may use another definition for other purposes, but not for health benefits eligibility.

Under What Circumstances May A Carrier Impose A Pre-Existing Condition Exclusion On Any Members Of My Group?

If your group contains six or more employees, the carrier is prohibited from imposing a pre-existing condition exclusion, except, in the case of late enrollees. If your group consists of two to five eligible employees, the carrier may decline to pay, for six months following the covered person's eligibility date for coverage, or the beginning of an employee's waiting period imposed by an employer, for treatment of a medical condition which was diagnosed and/or treated in the preceding six months. The "eligibility date" for an employee serving an employer's waiting period is the first day of the employer's waiting period.

Does Prior Coverage Protect A Member Of My Group From A Pre-Existing Condition Exclusion?

Yes, under most circumstances. An employee will be credited for any "creditable coverage." Creditable coverage includes individual or group insurance, and self-funded, or government funded (e.g., Medicare, Medicaid) health coverage so long as the coverage has not lapsed for more than 90 days. There are some exceptions in the law, so consult your agent, broker, carrier or lawyer.

May A Carrier Ask My Employees For Health Information?

Yes. However, health information cannot affect the premium and may not be used as a basis for denying coverage. It may only be used for the purpose of determining pre-existing conditions.

Once I Have Purchased A Small Employer Health Benefits Plan, May A Carrier Continue To Require Me To Complete Forms?

Yes. The carrier must require you to fill out an annual employer certification form in order to determine the number of employees and your participation rate. Failure to provide this information will result in non-renewal of coverage.

May I Offer My Employees More Than One Health Benefits Plan?

Yes. For instance, you could offer your employees an HMO plan, a PPO plan, and an indemnity plan.

How Would Carriers Determine The Premium For My Group?

Carriers may consider the age, gender, and family status of employees in the group, and the location of the business in New Jersey in determining the premium. Carriers may not consider the health status, nature of business, or past claims experience of a group in determining premium.

Are Rates Guaranteed For A Specific Period?

That is up to the carrier. Ask the carrier or your broker or agent if rates are guaranteed and for how long.

What Can I Do If I Am Unhappy With The Rates Being Charged By My Current Carrier?

You may be able to switch to a lower cost plan offered by your current carrier, or switch to another carrier offering lower rates. One of the goals of the reforms was to provide for "portability." Portability enables you to shop around for coverage from another carrier without having to worry about new pre-existing condition exclusions. Remember, even if your employees or their dependents are considered poor health risks, all carriers must accept your group for coverage, and the premiums charged may not be based on health status or prior claims history.

What Is "Self-Insurance" And "Stop Loss" Or "Excess Risk" Insurance?

Some employers, especially large employers, opt to provide health coverage to their employees through a self-funded arrangement. Under such an arrangement, the employer is liable for expenses for the health coverage offered to the employees. Most employers that self-fund elect to purchase "stop-loss" or "excess risk" insurance for some portion of their potential liability from claims under the contract for health coverage.

Stop loss and excess risk insurance is designed to reimburse the self-funded arrangement for catastrophic, excess or unexpected claims expenses. If an entity offers you a stop loss or excess risk plan and you are a small employer, make sure the limits in the plan, which are called "attachment points," are at least \$20,000 per person and 125 percent of expected claims per year. If a plan is offered to you with lower attachment points, the plan should not be offered or renewed and you should contact the SEH Board.

What Is The Impact On A Small Employer Group With Fewer Than 20 Employees With A Full-Time Employee Turning Age 65 And Becoming Eligible For Medicare?

There are several issues to consider, from the employee perspective as well as the employer perspective. First, eligibility for Medicare does not preclude eligibility for coverage under the employer plan. Thus, the employee may be covered under both Medicare and the group plan. Second, while the employee may be covered under both Medicare and the group plan, there will be a coordination of benefits. There are rules to determine which plan pays first and which plan pays second. In this example where the employer has less than 20 employees, Medicare is the primary carrier, and must pay first. The employer plan will be the secondary carrier.

The purpose of a coordination of benefits is to allow a person to claim benefits from both Medicare and the employer plan, with the primary carrier paying benefits as if there were no other coverage, and the secondary carrier paying up to the difference between what the primary carrier paid and the amount of the allowable charge. Lastly, there may be an impact on the group rate. Carriers may, but are not required to, consider Medicare eligibility in establishing rates, recognizing the fact that as the secondary payor, there is a reduced liability.

What Should I Do If I Have Questions That Are Not Answered Here?

Contact your broker, agent or carrier for clarification or assistance. You can also visit the SEH Board's Web site at www.nj.gov/dobi/reform.htm. If you receive conflicting information from a carrier, broker or agent, contact the New Jersey Small Employer Health Benefits Program, P.O. Box 325, Trenton, NJ 08625 or you may fax your inquiry to (609) 633-2030